Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 19, 2017

Ms. Brenda Egbert, Manager
Bradford Oasis
92 Cottage Street
Bradford, VT 05033-8897

Dear Ms. Egbert:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on January 9, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 01/09/2017

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BRADFORD OASIS	92 COTTAGE STREET BRADFORD, VT 05033

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R100	Initial Comments: An unannounced on-site survey was conducted from 1/10/17 - 1/11/17 to investigate a facility self-report to the Licensing Agency. The following regulatory violations were found..	R100		
R101 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility accepted for admission to the home a resident who met nursing home level of care and whose needs exceeded the home's capacity to safely and appropriately care for. This practice affected 1 applicable resident of the home. (Resident #5). Findings include: Per review of the admission assessment for Resident #5, and interviews with the RN and caregiver, the resident required extensive weight bearing staff assistance for most ADL (Activities of Daily Living)completion and was on a waiver for being at nursing home level of care at the transferring facility. During interview, the caregiver stated that the resident was not able to reposition themselves in bed or in a chair without assist of 1 staff. The resident required weight bearing assistance for all mobility needs. The resident had extreme weakness and a very	R101		

R101 - R282 POCs accepted w/ addendum 4/19/17 MP attorney RN/pmc

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R101	Continued From page 1 unsteady gait per observation of an ambulation attempt made during survey at 1:30 PM on 1/11/17. During interview, the RN/ADM (Registered Nurse/Administrator)confirmed that the resident was on a waiver at the previous facility and that they had admitted the resident even though they were aware of the resident exceeding the needs for acceptance in a Residential Care Home facility.	R101		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that 4 of 5 residents in the sample received care in accordance with each resident's personal, psychosocial, nursing and medical care needs. (Residents #1, #2 #4 and #5). Findings include: 1. Per review of the medical record, Resident #1 experienced a change in medical condition after accidentally ingesting another resident's medications when the med tech (unlicensed staff member delegated to administer medications) left the area after placing the medications on the dining room table between 2 residents. A	R126		

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R126	Continued From page 2 Resident Accident/Illness/Incident Report - Abuse /Neglect/ Exploitation, dated 9/18/15 noted the following: "(staff name) was administering meds when a phone call distracted, (Resident #1) was sitting at the table waiting for their medications when the resident took the medications that were prepared for another resident. The medications included Seroquel 300 mg., Trazadone 150 mg. and Lithium 450 mg. S/he quickly became drowsy and was helped to bed." Per review of the Medication Error Report dated 9/17/15, the RN on call was notified by staff at 2200 hours (10 PM) that at 2000 hr. (8 PM), The resident took another resident's medications after they were placed on the table between him/her and another resident, and the med tech left the table for a phone call. The RN wrote that observable effects of the error included the following: sleepy, restless, speech inaudible. During interview regarding this error, the RN on call confirmed that they did not notify the physician nor provide any written instruction to staff on duty and s/he did not come into the facility to assess the resident until the following morning. The resident was not prescribed any antipsychotic medications and the dosages were above recommended levels for the elderly. Per review of the Nursing Drug Handbook Guide (2011), Trazadone, a antidepressant, can interact with Lithium and increase risk of seizure. Lithium has a half life of up to 36 hours in the elderly and requires monitoring for 8 - 12 hours after the initial dose due to the narrow therapeutic margin of safety. In addition, Seroquel is known to increase mortality in elderly patients. Despite the serious risk to the resident after ingesting these psychoactive medications, the RN failed to take	R126		

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R126	Continued From page 3	R126		

appropriate and prompt action to help assure the resident did not suffer serious adverse effects after the accidental medication ingestion. Per interviews with the on call RN on the afternoon of 1/10/17 and the RN/ADM on 1/11/17 at 2 PM), neither RN notified the physician to see if further treatments or action was required.

Per the RN/ADM's documentation dated 9/18/15, the resident was still very groggy the next day "...was sitting on the side of the bed and slipped to the floor, hitting [h/his] head when falling...and raising a bump...a small goose egg over the right eye; small scrape also...up for lunch...still groggy".
Although the daughter was notified of the error (per documentation dated 9/18/15), the physician was never notified of the significant error despite the risk to the resident. There was no documented timely RN assessment of the resident after the event; the information documented the following day did not indicate a thorough nursing assessment was done. Additionally, the med tech did not report the event until 2 hours after the error occurred, further increasing the risk to the resident.

2. Per observation during the initial tour of the facility on 1/10/17 at 10:20 AM, Resident #4 had skin tears, partially scabbed over on both hands, near the middle knuckle of each hand. The wound on the left hand appeared to have yellowish exudate in the wound. The wounds were approximately 1 cm. in diameter, with the left hand wound having an area of redness extending approximately 3 cm. around the open area. When asked to flex the fingers, the resident complied; when asked if there was any pain in doing so, the resident stated 'Yes'. The resident has dementia and could not say when the

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R126	Continued From page 4 wounds had happened, saying "I guess I scraped them". When the RN present was asked about the wounds on 1/10/17, and how they were acquired, s/he started they were not previously aware. The RN was on call over the weekend until the RN/ADM returned from a trip out of state, due back the following day on 1/11/17. Per review of the medical record for Resident #4, there were no progress notes regarding the resident's wounds. The RN stated that caregivers write daily notes for all residents in a single log book. Per review, there were no entries for the previous 5 days related to the wounds on the hands or when they were first noted. There was no evidence of notification of the injuries to the physician and family. A caregiver who arrived after the surveyors arrived (1/10/17) stated that s/he thought the resident's granddaughter mentioned that she needed Band-Aid for skin tears sometime over the previous weekend however, there was no documentation found concerning the wound. Later in the afternoon of 1/10/17, the caregiver was observed applying bandages to the 2 wounds. The following day, 1/11/17, the bandages, which looked the same as the ones applied the previous day were removed and the skin tears had increased drainage and were both red around the wounds. There were no new nursing orders received related to the wounds since they were noted by the surveyors and brought to the RN's attention the previous day. There was no documented evidence that the MD was notified of the wounds after they were brought to the RN's attention on 1/10/17. Refer also to R 189. 3. Per staff interview and record review, Resident #2 had a mental illness with an anxiety disorder and the facility failed to provide appropriate necessary training for staff to help address the	R126		

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R126	Continued From page 5 resident's emotional, psychosocial and medical needs. Based on review of documented behavior sent to the Licensing Agency as proof of unreasonable resident outbursts, the main concerns seem to be that the resident is considered intrusive with their questions and gets very upset (leading to outbursts at times) if not answered timely. There are patterns of behaviors documented illustrating that staff refuses to clarify simple requests of the resident and also does not employ effective strategies for redirection if the resident becomes disruptive. For example, on one occasion the resident came for medications just before noon (12/6/16) and asked "Can I get my meds?". Staff responded "please sit"; there was no clarification just a response that failed to recognize the resident's request. This type of staff response was seen per review of documentation related to other residents in the sample. Staff responses to reasonable questions are often terse and could easily agitate a resident who simply is asking a question and expecting a reasonable reply to that question. Per review of staff training and confirmed during interview with the RN/ADM on 1/11/17, many of the trainings are reading study guides with a quiz after. Per review of the training log, the time frames for some mandated training are 30 minutes each (regulations require a minimum of 60 minutes each). The records did not show that new hires demonstrated competency in the RCH (Residential Care Home) 7 required trainings before working with residents. The training log was incomplete and lacked dates of trainings. The ADM stated that 2 residents have challenging behaviors but there was no evidence of specific on-going training for direct care staff to address this need.	R126		

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R126	Continued From page 6 4. a. Per record review, Resident #5 was admitted to the home without current signed orders from their primary care provider on 11/09/16. As of the date of survey completion, 1/11/17, there were still no signed orders by the primary care provider. b. During interview on 1/10/17, the caregiver stated that the Resident #5 required extensive physical assistance for all ADL activities. During an observation in the resident's room, the bed was noted to have a half side rail in the up position. It was a hospital type bed which the RN present stated came to the facility with the resident upon admission. It was noted that the mattress was soft and had a large gap between it and the side rail, as well as an air mattress overlay, that posed an entrapment risk for the resident. The care giver said that the resident did not use the side rails, and that staff reposition h/her in bed. The RN was asked if there had been a safety assessment of the bed and side rails and she confirmed that she was not aware of one being done and that she had not completed an assessment to assure that the bed was safe for the resident. c. The resident informed the surveyor at 1:30 PM on 1/11/17, that they needed to go to the bathroom. The surveyor relayed this information to the RN/ADM who was sitting less than 6 feet away eating lunch in the kitchen. The RN stated that as soon as the caregiver was done helping another resident, they would assist h/her to the bathroom. (Another RN was sitting at the dining room table at the time, not eating but did not offer to help; there was a vacant bathroom in the adjacent hallway at this time). At 1:40 PM the RN/ADM came over to assist the resident to the bathroom. The RN asked the resident to stand and walk to the bathroom with the walker. The resident stated "I don't do so good." and said they	R126		

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R126	Continued From page 7 needed help and 'couldn't do it'. The RN repeatedly refused to help saying, "I will help you after you stand up". After a few minutes of this verbal back and forth, the RN held onto the back of the resident's pants and provided weight bearing assistance. The resident attempted to stand when h/her right foot slipped out from under h/her and s/he fell back into the chair. At this point the resident stated "I'm going to pee my pants." The RN stated "that's OK you have a brief on." The RN's on-going refusal to help the resident to the bathroom was a violation of the resident's rights and showed disregard for the resident's urgent need to toilet and ignoring her medical need. During interview after this observation, the RN/ADM stated that the resident is able to walk and had demonstrated that after admission to the facility. The resident's many medical conditions, including traumatic hip fracture within the past year and chronic pain issues demonstrate that the resident's abilities may fluctuate through the day and at times, during the week. The RN/ADM confirmed that they did not have any Long Term Care experience working with a frail elder population. The RN's failure to treat the resident with respect and dignity and provide timely assistance to the resident was confirmed at the time of the observation. Refer also to R 213.	R126		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the	R128		

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R128	Continued From page 8 physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident of the home received care consistent with physician orders for all medications, treatments and dietary services for 1 resident in the sample. (Resident #5). Findings include: Per review of the medical record, Resident #5 was admitted to the facility with no current signed physician orders. There were no signed primary care provider orders since admission as of the date of survey completion, 1/11/17. The resident has many comorbidities including cognitive impairment, fatigue and weakness, impaired vision and hearing, constipation and has chronic pain daily. Medical history diagnoses (per review of a podiatrist visit summary) include: HX of weight loss, Parkinson's tremor, depression and anxiety, cataracts, chronic abdominal pain, hypertension, coronary artery disease, renal insufficiency, peripheral vascular disease, elevated cholesterol and a traumatic hip fracture within the last 12 months. Per review of the admission assessment of 11/16/16, the resident requires extensive physical assistance of 1 staff for all transfer and mobility needs as well as performance of ADL activities. The lack of provider signed orders was confirmed with the RN on the afternoon of 1/10/17.	R128		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2)	R145		

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R145	Continued From page 9 Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to revise the care plan for 1 applicable resident in the sample to address the resident's current identified needs. (Resident #1). Findings include; Per review of the care plan for Resident #1, the plan stated that the resident uses a CPAP (Continuous Positive Airway Pressure) machine nightly to treat sleep apnea. Per interview on 1/11/17, the RN stated that the resident does not like the machine and is no longer using it nightly. Regarding a plan related to the resident's performance for self testing of blood sugars and self injection of insulin, the RN noted during July, 2016, that cognitive testing was performed at the primary care provider's office on 7/26/16 and the results were not received yet. As of the date of survey 1/11/17, the care plan had not been revised to include the results of the tests conducted to show that the resident was assessed by the RN as being competent to self-administer insulin.	R145		
R147 SS=C	V. RESIDENT CARE AND HOME SERVICES	R147		

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R147	Continued From page 10 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a current list of each resident's medication, date ordered, dosage and frequency of administration, including side effects to monitor for. This practice affects all resident of the home. (Up to eleven capacity). Findings include: Per interview with the RN/ADM on the afternoon of 1/11/17, the facility had failed to maintain an accurate and current list of each residents medications to include: resident name, medication, date ordered, dosage and frequency of medication and likely side effects to monitor for.	R147		
R150 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by:	R150		

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R150	Continued From page 11 Based on observation ,staff interview and record review, the RN/ADM. (Registered Nurse Administrator) failed to assure that resident incidents/accidents were recorded in the medical record at the time of the occurrence, including any actions taken for 2 of 5 residents in the sample. (Resident #1 and #4). Findings include: 1. Per observation during the initial tour of the facility on 1/10/17 at 10:20 AM, Resident #4 had skin tears, partially scabbed over on both hands, near the middle knuckle of each hand. The wound on the left hand appeared to have yellowish exudate in the wound. The wounds were approximately 1 cm. in diameter, with the left hand wound having an area of redness extending approximately 3 cm. around the open area. When asked to flex the fingers, the resident complied; when asked if there was any pain in doing so, the resident stated 'Yes'. The resident has dementia and could not say when the wounds had happened, saying "I guess I scraped them". When the RN present was asked about the wounds and how they were acquired, s/he stated s/he was not aware. The RN was on call until the RN/ADM returned from a trip out of state. Per review of the medical record for Resident #4, there were no progress notes regarding the resident's wounds. The RN stated that caregivers write daily notes for all residents in a single log book. Per review, there were no entries for the previous 5 days related to the wounds on the hands or when they were first noted. There was no evidence of notification of the injuries to the physician and family. A caregiver who arrived after the surveyors arrived stated that she thought the resident's granddaughter mentioned that she needed Band-Aids for skin tears sometime over the previous weekend, however, there was no documentation found concerning the wound.	R150		

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R150	Continued From page 12 During interview regarding the lack of staff documentation in each resident's medical record for any changes in status or accidents etc. the RN confirmed that they all, including herself, write in the one log book for all resident incidents and daily issues. The RN said only the RN/ADM writes progress notes in the medical record. Per review, the RN/ADM progress notes are not usually daily and are often weekly, despite other daily concerns written in the log book by staff. Refer also to R 189. 2. Per review of the medical record for Resident #1, a Resident Accident/Illness/Incident Report - Abuse /Neglect/ Exploitation, dated 9/18/15 noted the following: "[staff name] was administering meds when a phone call distracted, [Resident #4] was sitting at the table waiting for their medications when the resident took the medications that were prepared for another resident. The medications included Seroquel 300 mg., Trazadone 150 mg. and Lithium 450 mg. He quickly became drowsy and was helped to bed." Per review of the Medication Error Report dated 9/17/15, the RN on call was notified by staff at 2200 hours (10 PM) that at 2000 hr (8 PM), the resident took another resident's medications after they were placed between him and another resident on the dining room table, and the med tech left the table when a phone call distracted him/her. The RN wrote that effect of the error included the following: sleepy, restless, speech inaudible. During interview regarding this error, the RN on call stated that they did not notify the physician nor provide any written instruction to staff on duty and s/he did not come into the facility to assess the resident until the following morning. The resident was not prescribed any antipsychotic medications and the doses were high for an elderly resident. Per review of the	R150		

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R150	Continued From page 13 Nursing Drug Handbook guide (2011), Trazadone, an antidepressant, can interact with Lithium and increase risk of seizure. Lithium has a half life of up to 36 hours in the elderly and requires monitoring for 8 - 12 hours after the initial dose due to the narrow therapeutic margin of safety. In addition, Seroquel is known to increase morbidity in elderly patients. Despite the serious risk to the resident after ingesting these psychoactive medications, the RN failed to take appropriate and prompt action to help assure the resident did not suffer serious adverse effects after the accidental medication ingestion. Per interviews with the on call RN on the afternoon of 1/10/17 and the RN/ADM on 1/11/17 at 2 PM, neither RN notified the physician to see if further treatments or action was required. Per the RN/ADM's documentation dated 9/18/15, the resident was still very groggy the next day "...was sitting on the side of the bed and slipped to the floor, hitting his head when falling...and raising a bump...a small goose egg over the right eye; small scrape also...up for lunch ...still groggy". Although the daughter was notified of the error (per documentation dated 9/18/15), the physician was never notified of the significant error despite the risk to the resident. There was no timely RN assessment of the resident after the event until the following day. Additionally, the med tech did not report the event until 2 hours after the error occurred, further increasing the risk to the resident. The RN on call confirmed during interview at 4:20 PM on 1/11/17, she was aware that the incident had occurred at 8 PM on 9/17/15 when s/he was called at 10 PM.	R150		
R155 SS=G	V. RESIDENT CARE AND HOME SERVICES	R166		

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R155	Continued From page 14 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the facility facility RN failed to assure that staff were competent in their administration of medications to all residents for 1 applicable resident in the sample. (Resident #1). Findings include: Per review of the medical record, Resident #1 experienced a change in medical condition after accidentally ingesting another resident's medications when the med tech left the area after placing the medications on the dining room table between 2 residents. A Resident Accident/Illness/Incident Report - Abuse /Neglect/ Exploitation, dated 9/18/15 noted the following: "[staff name] was administering medications when a phone call distracted, (Resident #1) was sitting at the table waiting for their medications when the resident took the medications that were prepared for another resident. The medications included Seroquel 300 mg., Trazadone 150 mg. and Lithium 450 mg. [S/he] quickly became drowsy and was helped to bed." Although the resident was at great risk due to this significant medication error/event, there was no written evidence of an effective general medication administration safety training for all medication delegated staff after the event. The resident recovered but also sustained an injury due to falling out of bed and hitting the head, due to effects of the medication.	R155		

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R155	Continued From page 15 NOTE: Deficiencies related to staff leaving medications unattended in resident areas were cited on 3 previous surveys (7/26/16, 6/15/16 and 5/9/16.) The facility has failed to assure that staff are competent with all aspects of safe medication administration.	R155		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN/ADM failed to assure that each resident's medication regime was in accordance with current signed physician orders for 2 of 5 residents in the sample. (Residents #2 and #5). Findings include: Per review of the medication record and the MAR (medication administration record), there were no signed physician orders upon admission to the facility for Resident's #2 and #5. Per record review, Resident #5 was admitted to the home on 11/09/16 and is currently receiving multiple medications daily, with no signed primary care provider orders ever received. When the RN/ADM was asked to locate the admission orders for Resident #2 (admitted on	R162		

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R162	Continued From page 16 10/6/15 from another facility), s/he was not able to locate them in the current medical record nor in the previously thinned documents from the medical record. In addition, the Resident had a signed order in the medical record dated 12/23/16 to receive Metoprolol Succinate ER tablet 100 milligrams twice a day. The medical administration record for January 2017 directed staff to administer Metoprolol Succinate ER tablet 50 milligrams every morning and 100 milligrams every evening. The RN/ADM could not locate any change of medical orders to justify the discrepancy. This is a repeat deficiency from the survey of 5/9/16.	R162		
R165 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the	R165		

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R165	Continued From page 17 need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that all staff were properly trained in administration of medications to residents of the home. This failure has the potential to affect all residents of the home and did effect the care provided to Resident #1. Findings include: 1. Per review of the training for administration medications for one staff member on 1/11/17, there was no written information available for review of the content of the training, nor was there any written evidence of the RN's observation of the caregiver's medication administration to demonstrate competency prior to being allowed to administer medications to residents independently. The RN/ADM stated that s/he and another RN both provide informal discussions and training of caregivers, but there was no evidence to support the content and extent of the training provided. 2. Per record review and staff interview, Resident #1 was insulin dependent and received sliding scale doses of insulin (in addition to routine doses), depending on the results of finger stick blood glucose tests 30 minutes prior to meals daily. Per interview with the RN/ADM on 1/11/17, there is no written content or evidence of the training provided for unlicensed staff to be able to administer, or oversee resident blood sugar testing and self-administration of the insulin via an insulin pen. Resident #1 had no physician	R165		

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R165	Continued From page 18 order to self-administer h/her insulin. Additionally, there was no evidence of the RN's assessment of the resident's ability to self administer the insulin. If unlicensed staff are providing or assisting with insulin injections, there must be evidence of specific training related to administration of insulin and the potential risks associated with the effects insulin and of diabetes. Refer also to R 169.	R165		
R169 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance" versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to show evidence of training in the	R169		

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R169	Continued From page 19 required 5 areas as stated as part of the required medication delegation training for all unlicensed staff who administer medications to residents of the home. This practice has the potential to affect all residents of the home, up to the 11 resident licensed capacity. Per interview (1/11/17) and review of available training records, the RN did not use a formal written process for the training of medication administration for unlicensed staff. There was written evidence of only one staff training provided related to documentation of medications; no other written evidence was provided. Per review of the "Medication Administration Policies and Procedures" (2.5 pages), and the "Medication Administration Policy" (1.5 pages), there was no evidence of the dates and times of the trainings provided to the staff currently administering medications to residents of the home. There was no evidence of training on the signs, symptoms and likely side effects to be aware of for all medications being administered to residents. There was no written evidence of insulin training, including insulin administration via specific procedures for injectable medication.	R169		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to	R179		

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R179	Continued From page 20 residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed failed to assure that staff demonstrated competency in the skills they are expected to perform before providing direct care to residents and failed to keep complete and accurate training records for all care givers employed at the facility. This practice has the potential to affect all residents of the home. Findings include: Per review of the log provided denoting staff trainings, many trainings had no date; additionally, the time required to complete the self study guide for some trainings was 30 minutes, not the 1 hour length per RCH requirements. Review of 1 staff member's Abuse training revealed the training was 30 minutes total time to complete. The training for 'Respectful and	R179		

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R179	Continued From page 21 Effective Interactions' included no time. Dates were not present on the log. It was noted by surveyors during the survey (record reviews) that staff are often respond in a terse manner to certain residents of the home with 'behavioral' issues. Per review of care giver documentation in the resident log, the communication model used in the home to 'control unacceptable behaviors' often seemed to have to opposite outcome. An example of this manner of relating includes the following: resident may be asked about breakfast every morning, if they speak out of turn, instead of using positive redirection techniques, the staff might reply in a condescending manner saying "Say please", treating the residents like children. There are notes stating that resident responses include such words as" you make me agitated". This represents a lack of training in managing certain behaviors. The above concerns were confirmed with staff present during the survey. This is a repeat deficiency from the survey of 5/9/16.	R179		
R189 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation;	R189		

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R189	Continued From page 22 and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain complete and accurate records for 5 of 5 residents requiring nursing care. (Residents #1 through #5). Findings include: Per record reviews on 1/10/17 and 1/11/17, facility staff do not document each resident's care and incidence of illness and accidents, or changes in condition in the medical record of each resident. Per review and confirmed during interview with the RN on duty on 1/10/17, staff document resident issues for all residents in a common daily log book. Only the RN/ADM documents in the medical record. The RN stated that s/he also writes entries when needed in the common log book. The only progress notes found in the medical records were documented electronically by the RN/ADM. The medical records also failed to include: the physician's statement upon admission for all residents reviewed (#5) and the admission orders for 2 residents reviewed (#4 & #5). Refer also to R 150.	R189		
R213 SS=E	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights.	R213		

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R213	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, facility staff failed to treat the resident(s) with consideration, respect and in full recognition of the resident's individuality for 4 of 5 residents in the sample. (Resident #5, # 1, #3 and #6). Findings include: 1. Resident #5 was weak, underweight, frail and dependent on staff for completion of ADLs daily, per staff interview with the caregiver and review of the resident's admission assessment. The resident informed the surveyor at 1:30 PM on 1/11/17, that they needed to go to the bathroom stating "I'm very uncomfortable". The surveyor relayed this information to the RN/ADM who was sitting less than 6 feet away eating lunch in the kitchen. The RN stated that as soon as the caregiver was done helping another resident, they would assist h/her to the bathroom. (Another RN was sitting at the kitchen table at the time, not eating but did not offer to help). There was a vacant bathroom in the adjacent hallway at this time. At 1:40 PM the RN/ADM came over to assist the resident to the bathroom. The RN asked the resident to stand up from their chair, using the walker placed in front of them. The resident "I don't do so good" and said "I need help". The RN repeatedly refused to help saying, "I will help you after you stand up". After a few minutes of this verbal back and forth, the RN held onto the back of the resident's pants and provided a minimum of weight bearing assistance. The resident attempted to stand when h/her right foot slipped out from under h/her and s/he fell back into the chair. At this point the resident stated "I'm going to pee my pants." The RN stated "that's OK you have a brief on." The RN's on-going refusal to help the resident to	R213		

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R213	Continued From page 24 the bathroom was a violation of the resident's rights and showed disregard for the resident's urgent need to toilet and ignored h/her medical need. The resident said 'I can't do it' again. The caregiver became available and the resident was subsequently assisted to the toileted via wheelchair. During interview later in the day, the RN/ADM stated that the resident was able to walk and had demonstrated that after admission to the facility. The resident's many medical conditions, including traumatic hip fracture within the recent past, sensory impairments and chronic pain issues demonstrate that the resident 's physical functioning may fluctuate throughout the day and during the week. The RN/ADM confirmed that they did not have previous relevant experience working in a Long Term Care setting with a frail elder population. The RN's failure to treat the resident with respect and dignity and provide timely assistance per resident request was confirmed at the time of the observation. 2. Per observation throughout the two days of survey, Resident # 3 was observed eating alone in the living room while other residents ate their meals at the kitchen table. When asked why they were eating in the living room, the resident explained it was because s/he was "bad" and was not allowed to eat with the others. Per interview with the RN/Administrator on 1/11/17, she explained that the Resident had been bad as she gave frequent directions to staff and other residents during mealtimes, which was considered to be disruptive. Staff did not discuss with the Resident why she issued such directions, but instructed her that she could not sit at the kitchen table with others during meal times until she changed her behavior.	R213		

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R213	Continued From page 25 3. Per interview with a surveyor on 1/11/17, Resident # 1 stated that he was no longer allowed to attend two daily activities; the senior center luncheon and a trip to the local Walmart afterwards because he demonstrated outbursts when in common areas in the home. During interview on 1/11/17, the RN/Administrator confirmed that she told the Resident that he could not go to the senior meal site even though they enjoyed him and welcomed his company. She also confirmed that he was told he could not go to Walmart either until he improved his behavior. 4. Per interview with a surveyor, one resident (#6) who did not wish to be identified, stated that they would like to be able to have juice for a snack drink. They stated that juice was only allowed at breakfast and if a resident wanted juice at another time of the day, it was not allowed. Staff confirmed that juice is only to be served at the breakfast meal, no other times of the day were allowed.	R213		
R227 SS=D	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance	R227		

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R227	Continued From page 26 with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure protection of each resident's right to refuse care/treatments after they are fully informed of the potential outcomes of such refusals of care for 1 applicable resident in the sample. (Resident #1). Findings include: Per observation of the menus in the kitchen area and interviews with staff on 1/10/17, diabetic residents of the home are allowed only the exact serving sizes of certain food groups and are limited to certain food groups for second servings if they so desire. During an observation of lunch service, some residents received 4 - 5 potato chip pieces and 4 slices of pickles with a sandwich for lunch. The menu listed the lunch meal as tuna sandwich (only), no other foods were listed. Staff said that sometimes Resident #1, who has diabetes, requests seconds. The resident is only allowed seconds of a protein food group, not fat or carbohydrate. Per interview with the RN on duty on 1/10/17, s/he also confirmed that if Resident #1 was to go out of the facility and purchase and bring back unhealthy high sugar and carbohydrate foods, they would not be allowed to keep them at the home. When asked if the resident wanted to keep them in the home's kitchen and labeled with their name, would that be allowed and the RN stated "no". The RN also does the weekly menus for the home. Per interview with staff on duty, regarding substitutions for an alternate meal if desired, staff stated residents are to be offered a peanut butter and jelly sandwich, that is the alternate meal.	R227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD OASIS	92 COTTAGE STREET BRADFORD, VT 05033

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R227	Continued From page 27 When the RN was also asked about alternate meal choices for any resident that does not like the meal listed on the menu on a given day, the RN said that they may have a peanut butter and jelly sandwich. When questioned further if that was the only choice, the RN said "soup". She also said that if there were any leftovers they could have that instead of the listed meal. The residents' right to refuse care and to self determination regarding food choices has not been consistently allowed, per interviews during the survey.	R227		
R232 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the menu posted at the home was not been complete and did not include all foods planned and available for each meal at the time of the survey. This practice could affect all residents of the home. Findings include: Per review of the menu posted in the kitchen of the home on 1/10/17, the meal for lunch on 1/10/17 was listed only as "tuna sandwich". No vegetable and /or fruit or drinks or dessert was included. Per interview with the RN who writes the menus for the home, s/he stated that they can also have fruit that is available in the home and a choice of drink. The requirement to include nutritious, balanced, attractive meals was	R232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R232	Continued From page 28 reviewed with the RN. The written menu should include all foods/drinks to be served at each meal.	R232		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to provide a functional and comfortable dining area for all residents of the home. All residents are potentially affected by this practice. Findings include: Per observation of the dining room area for the noon meal on 1/10/17, the table can comfortably seat 8 residents, a small table that opens up near the entrance to the living room is expanded to provide seating for 2 other residents, and 1 resident was eating alone at a table in the living room. With the expandable table pulled out, there is not room for residents and staff to easily maneuver to and from the table. (The capacity for the home is 11 residents). Residents may be required to stay at the table longer than they prefer, or may have to wait if they need to use the restroom during mealtimes. The facility's dining arrangements were not functional for all residents of the home.	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 01/09/2017

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R282	Continued From page 29	R282		
R282 SS=E	IX. PHYSICAL PLANT	R282		

9.4 Recreation and Dining Rooms

9.4.a All homes shall provide at least one (1) well-lighted and ventilated living or recreational room and dining room for the use of residents.

This REQUIREMENT is not met as evidenced by:
Based on observation, the home failed to provide a well-lighted living room for use by the residents of the home. This practice has the potential to affect all residents of the home. Findings include:

Per observation of the living room after 4 PM in the afternoon, there were 3 lights in the room, all of them on one side of the room. The other side had no lights and was very dark; this would impair a resident's ability to engage in reading or certain games if desired. The lack of sufficient lighting could also pose a fall/accident risk, as many of the residents of the home have diminished eye sight. These concerns were confirmed with the staff present at the times of the observations.

BRADFORD OASIS

PLAN OF CORRECTION

APRIL 14, 2017

✓ R101. 5.1. Eligibility

I did not realize the person was on a waiver. She was described by care givers as level III appropriate. RN/ADM will not admit anyone above licensed care level. RN/ADM will carefully interview and evaluate potential residents for appropriate level of care. Waivers will be sought as needed. RN/ADM will be responsible for this. This practice is in place. 2/8/17.

R126. 5.5. 1. General Care

Staff did not notify RN of med error in a timely manner. Facility did not seek medical advice and notify PCP in a timely manner. ASAP notification of RN by staff and PCP notification/advice by RN is now standard practice. RN/ADM will follow up on any care/incident issues. This is in place 2/8/17.

R126. 5.5. 2.

RN/ADM have reinforced to staff the need for documentation of any resident injury. RN/ADM will follow up on any injury and notify PCP and request treatment orders. RN/ADM will ensure that appropriate notes are written by staff. This is in place 2/8/17.

R126. 5.5. 3.

RCH regulations do not require 1 hour sessions. Some formal training sessions are only 30 minutes. Further training takes place in staff meetings to meet individual resident needs. Reinforcement is conducted for individual residents as needed. RN/ADM now keep more detailed records of training sessions. RN/ADM will ensure that all orienting staff complete the 7 required trainings before caring for residents. RN/ADM will conduct further instruction on behavioral issues as needed. In place 2/8/17.

R126. 4a.

This resident was admitted without complete documentation, signed MD orders, due to an emergency situation. This is no longer allowed. All residents will have now complete documentation presented to RN/ADM before admission is considered. Signed MD orders are in place for all residents. 2/8/17.

R126. 4b.

Side rails are no longer permitted even if not used or at family insistence. The resident cited is no longer here. RN/ADM will ensure this 2/8/17.

R126.c.

This resident's needs were not met in a timely manner or appropriately. The other person at the table was neither an RN nor staff member. The RN mentioned was no longer in the house at this time. It has been reinforced that resident needs take precedence over staff needs and resident limitations are appropriately accommodated. The resident cited is no longer here. RN/ADM will monitor staff/resident interactions and intervene as needed. In place 2/8/17.

R128. 5.5.

As above, R126. 4a. No resident will be admitted without full documentation, including MD orders, presented to RN/ADM beforehand. Meds provided will be in

accordance with MD orders before they are administered to residents. 2/8/2017.

R145. 5.9.c.

Care plans are reviewed monthly and updated by RN/ADM as needed. Care plans are updated whenever a new problem occurs or revision is required. RN/ADM is responsible for this. 2/8/17.

147. 5.9c.

We have had difficulty getting written orders after verbal orders. It has sometimes taken several requests and even a few weeks before we received necessary orders. MD will be notified by RN/ADM that meds will not be given until signed written orders are available. RN/ADM will in responsible for this. 2/18/17.

R150. 5.9.c.

Instruction on incident reports by staff has been reinforced. They are now used appropriately and at the time of occurance. Proper med admin procedures have been reinforced. We obtained a med cart and instituted new med practices after this event. We have had no such incidents in the past 2 years. RN/ADM monitors and provides ongoing instruction.

R155

The staff member(s) who left meds unattended were re-educated on proper med admin and were observed through several med passes by RN/ADM. Those who had difficulty complying no longer work here. Proper med admin is emphasized by RN/ADM during orientation. RN/ADM will conduct random casual observations weekly. 2/8/17.

R162. 5.10.c

As described before, residents will no longer be admitted without complete documentation and MD orders even in apparent emergency situations. RN/ADM will ensure this. 2/8/17.

It took several requests to PCP for clarification of this order. Orders will not be changed until written confirmation is received. RN/ADM will ensure this. 2/8/17.

R165. 5.10.d

Bradford Oasis has an inclusive med training program that was developed in conjunction with another RCH. We have documented training but had not used a detailed list. We now have a detailed list of tasks and competencies.

We now have written MD orders related to resident competency for glucose checking and self-administration of insulin.

Administration, uses, and side effects of medications are always in the resident med record and available through other resources. Particular meds/side effects are covered in orientation. Insulin injection and drug info will be reinforced whenever a diabetic resident is admitted. RN/ADM is responsible for this education. 2/8/17.

R169.5.10.e.

Bradford Oasis has an inclusive med training program that was developed in conjunction with another RCH. We have documented training but had not used a detailed list. We now have a detailed list of tasks and competencies. RN/ADM will be responsible for this documentation. 2/8/17.

R179. 5.11. b

We have more than 12 hours of training in a year. Some employees had not been

working long enough to complete the 12 hours. Some of the 7 required trainings were not complete because employees had left before completing orientation. We are now documenting training with the date and not only completion. We have reviewed appropriate communication with residents. RN/ADM will be responsible for this education. 2/8/17.

R189. 5.12. b.

We now have daily individual notes as well as the daily general log. These notes are in addition to nursing notes.

Progress notes are signed MD visit notes and orders. These are reviewed by RN/ADM several times weekly and visit notes are reviewed as they occur. RN/ADM will ensure this. 2/8/17.

R213. 6.1

1. This resident was not attended in the best manner. The smaller bathroom is much more difficult to manage with a walker. The other person at the table was neither an RN nor an employee, but a guest. The RN mentioned was in the house for a short time and was not present during the incident. We now take resident's needs and concerns in a timely manner. The need to care for residents first is our focus. This is emphasized in orientation and as needed. RN/ADM will ensure education and monitor staff compliance.

2. This resident regularly created disturbance during meals. Her disrupting behavior was discussed with her and she was asked to stop on many occasions. Finally, she was told she would sit away from the table if she continued this behavior. She was moved to the living room for meals. Mealtime environment became much calmer for the residents. We did not at any time call her "bad" and we did discuss her disruptive behavior with her several times before moving her location. She is now back at the table and no longer has disrupting behavior. It can be difficult at times to weigh the rights of a group against the rights of one. RN/ADM will monitor and uphold resident rights. 2/8/17.

3. This resident was restricted from outside activities because of his inappropriate sexual behavior toward residents, staff, and visitors. This behavior was also reported to me by attendees of the senior center. He is no longer at this residence. RN/ADM will monitor and uphold resident rights. 2/8/17.

4. It has been the practice of serving juice primarily at breakfast. Juice is now available at any time. Kitchen manager will ensure juice is always available. Review training on resident's rights has been accomplished. 2/8/17.

R227. 6.5.

I'm not sure what refusal of care to the extent of the law entails. We understand that residents are here because they need a structured environment for medical, physical, dietary, or activity needs and we are required to provide for those needs. We now understand that we are not allowed to enforce any of these needs even when MD ordered and residents may make their own choices. These choices are accepted by us, appropriate advice given, choices and advice documented, and reported to PCP as needed. RN/ADM will be responsible for upholding resident rights, advice, and documentation. Resident rights retraining has been held. 2/8/17.

R213 Addendum: RN/ADM now have a more complete understanding of resident rights. We have held several staff meetings to review rights and how they impact the care we provide. I have also contacted the ombudsman to provide a training for us. I am awaiting her response. Tentative completion: mid-may. * Per email from manager on 4/19/17. PMcotaRN

R232. 7.1. a.

Menus are now posted in minute detail for ingredients, substitutions, and alternatives. We no longer restrict residents on prescribed diets. Kitchen manager will be responsible. 2/8/17.

R256. 9.1.

Seating in the dining room has been changed to afford increased mobility and comfort. Lighting has been improved in the living room. A new light has been added. Residents have now told us they are hesitant to turn on lights so we turn on lights when it becomes too dark. We are already in the habit of turning on room lights and hall lights as they become dark. Staff and RN/ADM will be diligent in providing proper lighting and environment for residents. 2/8/17.

Brenda Egbert, RN. 4/13/2017